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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Sept. 13 2018
BY [signature] ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Martin C. Schulman, M.D.** **P.O. Box 746** **Cardiff By the Sea, CA 92007** **Physician's and Surgeon's Certificate No. G 58731,** Respondent.	Case No. 800-2017-033979 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 22, 1986, the Medical Board issued Physician's and Surgeon's Certificate No. G 58731 to Martin C. Schulman, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. . ." [Chapter 5, the Medical Practice Act.]

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) . . .

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . ."

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7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G 58731 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:[1]

9. In or about August 2006, Respondent, a family care practitioner, began treating Patient A for his primary care needs. At the time, Patient A had completed a detoxification program for abuse of alcohol and hydrocodone. He also suffered from chronic back pain due to degenerative spine disc disease.

10. Respondent did not treat Patient A again until on or about January 6, 2010, when Patient A re-established care with Respondent as his primary care doctor. During this visit, Patient A told Respondent that he was drinking alcohol again on a weekly basis, but was not taking any opiate medications. Patient A told Respondent that he enjoyed drinking alcohol and it helped him to relieve his stress.

11. On or about March 8, 2010, Patient A went to the emergency room due to worsening back pain. Thereafter, Patient A took tramadol for back pain and diazepam[2] for anxiety.

12. On or about April 27, 2010, Respondent noted that Patient A took diazepam to help him get through alcohol withdrawal.

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[1] References to "Patient A" herein are used to protect patient privacy.

[2] Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Over the next six months, Respondent regularly refilled Patient A's tramadol and diazepam prescriptions. Respondent also began to prescribe oxycodone[3] to Patient A. During this timeframe, Respondent noted in the medical records that Patient A continued to drink alcohol in order to relieve his back pain and stress, and that he also took diazepam to relieve his anxiety and alcoholic withdrawal symptoms on days that he did not drink.

14. On or about December 16, 2010, Patient A underwent spine surgery. His discharge medications included oxycodone, Oxycontin,[4] and diazepam.

15. On or about December 21, 2010, following Patient A's surgery, Patient A continued to experience pain, resulting in another hospital admission.

16. On or about January 8, 2011, Patient A had a post-surgery visit with Respondent. Patient A discussed his continuing alcoholism with Respondent. They also discussed chemical dependency and psychiatric treatment for Patient A. Prior to this visit, Patient A's daily oxycodone dosage was 160mg, his daily Oxycontin dosage was 40mg, and his daily diazepam dosage was 40mg. During this visit, Respondent decreased Patient A's daily oxycodone dosage to 120mg, but increased his Oxycontin dosage to 60mg. Respondent continued Patient A on diazepam, but decreased the daily dosage to 30mg.

17. On or about February 1, 2011, Respondent increased Patient A's daily Oxycontin dosage to 80mg. Patient A's daily oxycodone dosage was 120mg.

18. On or about February 3, 2011, Respondent increased Patient A's daily Oxycontin dosage to 120mg and his daily oxycodone dosage remained at 120mg.

19. On or about March 7, 2011, Patient A's daily oxycodone dosage was 120mg, his daily Oxycontin dosage was 120mg, and his daily diazepam dosage was 30mg.

20. On or about August 11, 2011, Patient A's daily oxycodone dosage was decreased to 90mg, and his daily Oxycontin and diazepam dosage remained 120mg and 30mg, respectively.

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[3] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Oxycontin is the extended release form of oxycodone, which is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Respondent continued to provide care and treatment to Patient A for the remainder of 2011 and through 2012.

22. On or about December 16, 2011, Patient A's daily oxycodone dosage was 90mg, his daily Oxycontin dosage was decreased to 90mg, and his daily diazepam dosage was 30mg.

23. On or about February 22, 2012, Patient A's daily oxycodone dosage remained at 90mg, his daily Oxycontin dosage was increased to 120mg, and his daily diazepam dosage also remained at 30mg.

24. On or about April 18, 2012, Respondent referred Patient A for a pain medicine consultation regarding intrathecal pumps and spinal cord stimulators. As of this date, Patient A's daily oxycodone dosage was 90mg, his daily Oxycontin dosage was 120mg, and his daily diazepam dosage was 30mg.

25. On or about May 9, 2012, Patient A had a pain medicine consultation. He was not deemed a candidate for a spinal cord stimulator. However, an intrathecal pump implantation was discussed with Patient A as an option and he was provided with further resources, including videos, to review at home. Patient A was advised that if he wished to proceed with the pump implantation, he had to stop his usage of long-acting opioid medications (but if medication aid was needed, it could be arranged through a psychiatrist). In addition, Patient A was advised that he had to be evaluated by a psychologist prior to the procedure. Patient A's current pain regimen and effectiveness was also reviewed and, according to the pain specialist, it was reasonable to continue Patient A on the current regimen.

26. On or about May 15, 2012, Respondent saw Patient A, who complained of worsening back pain. As a result, Patient A's daily oxycodone dosage was increased to 120mg. His daily Oxycontin dosage remained at 120mg and his daily diazepam dosage remained at 30mg. Respondent urged Patient A to watch the intrathecal pump implantation videos and to consider proceeding with the pump trial. If Patient A chose not to proceed with the trial, Respondent told Patient A that he could still see the pain specialist for suggestions on how to alter his pain medication regimen for better efficacy.

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27. Patient A continued to complain of worsening back pain and, on or about June 5, 2012, Respondent increased Patient A's daily oxycodone dosage to 150mg. His daily Oxycontin dosage remained at 120mg and his daily diazepam dosage was 30mg.

28. On or about June 20, 2012, Patient A complained that his pain had become steadily worse, prompting Respondent to, *inter alia*, confer with the pain specialist with whom Patient A consulted on or about May 9, 2012.

29. Between on or about June 20, 2012 and June 22, 2012, Respondent and the pain specialist discussed the need for Patient A to enter into a drug detoxification program and to undergo psychological evaluation before Patient A could be considered for participation in the intrathecal pump implantation trial. Respondent stated that Patient A needed more than a standard detoxification program, that a full chemical dependency program would be necessary, and that he would try to enforce a tapering down of his current medication regimen. The pain specialist responded that Patient A should call the pain management clinic and schedule a follow-up appointment, that he must be a patient of the clinic since his condition was chronic, that he would need a psychological evaluation, multidisciplinary team conference, and possibly counseling in order to be considered for the pump trial, and that the clinic had a psychiatrist/addictionologist who could assist with detoxification. The pain specialist stated: "There are some red flags that must be addressed before proceeding with a pump trial or it would be a disaster. And I cannot promise that he would be a candidate and must proceed with full evalation [sic] first. If you could reinforce this with him, it will help."

30. On or about June 21, 2012, Respondent attempted to call Patient A, but Patient A did not answer. The same day, Respondent spoke with Patient A's girlfriend and told her that he believed Patient A was developing a tolerance to his pain medications and that Patient A needed to taper down from the medications or to more acutely detox off of them, as well as alcohol, possibly in conjunction with participation in the pump implantation trial.

31. On or about July 11, 2012, Patient A's daily oxycodone dosage was 150mg, his daily Oxycontin dosage was decreased from 120mg to 90mg, and his daily diazepam dosage was 30mg.

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32. On or about August 7, 2012, Patient A's daily oxycodone dosage was 150mg, his daily Oxycontin dosage was increased back to 120mg, and his daily diazepam dosage was 30mg. During this visit, Patient A complained of worsening back pain. Respondent encouraged Patient A to watch the intrathecal pump implantation videos provided to him during his May 9, 2012, pain medicine consultation and to thereafter "go in for a trial of this treatment."

33. On or about August 28, 2012, Respondent increased Patient A's daily oxycodone dosage to 180mg and increased his daily Oxycontin dosage to 160mg. The previous day, on or about August 27, 2012, Patient A complained of "horific [sic] pain" at night and during the day. According to Patient A, he scheduled an appointment with the pain clinic for on or about September 12, 2012, but he could not wait that long for relief. Respondent gave Patient A the option of either taking Oxycontin 40mg every six hours or taking 40mg in the morning, 40mg in the afternoon, and 80mg (two 40mg tablets) in the evening, and Patient A chose the latter. Respondent told Patient A that he would check with the pain specialist to see if he could get him in sooner and get his input on what, if any, adjustments could be made to Patient A's pain medication regimen. Respondent also told Patient A that he would check with the surgeon who performed his December 16, 2010, spine surgery, to see if he wanted Patient A to come in for a further evaluation. Respondent noted that Patient A would be running out of his pain medications early and, therefore, Respondent planned to see Patient A again on or about August 31, 2012, to refill his prescriptions.

34. Between on or about August 27, 2012 and August 28, 2012, Respondent corresponded with both the pain specialist and surgeon. Respondent noted to the pain specialist that Patient A continued to drink "two 1.75 liter bottles of rum per week[,] though in the past it's been as much as three bottles. On nights when he does not drink he takes diazepam instead." Respondent told the pain specialist that Patient A should ideally undergo medication detoxification as part of getting an intrathecal pump implant. Respondent also stated that Patient A would be best served by medication detoxification and alcohol/drug rehabilitation.

35. On or about the morning of August 29, 2012, Patient A contacted Respondent and asked if he could come into the office to pick up "new stronger scripts for pain[.]" He told

Respondent that he had been up since 1:00 a.m. in severe pain and needed relief that day. Respondent advised Patient A that he was unable to see him until the following afternoon, but if he could not wait until then, he should consider going to the emergency room so that he could be evaluated for possible admission to the hospital for pain control. They also discussed the possibility of Patient A permanently switching to a pain specialist for better pain management. Patient A confirmed that he would come in to see Respondent the following afternoon.

36. On or about August 30, 2012, Patient A passed away.

37. During Respondent's care and treatment of Patient A, Respondent continuously prescribed oxycodone and Oxycontin to Patient A, however, Respondent did not have pain treatment contract with Patient A; he did not obtain Patient A's informed written consent to prescribe pain medications to him; he did not order routine urine toxicology testing to monitor potentially abusive and/or aberrant behaviors by Patient A; and he did not document any discussions with Patient A regarding the analgesic effects, side effects, and functional goals of taking oxycodone and Oxycontin.

38. Respondent committed repeated negligent acts in his care and treatment of Patient A, which included, but were not limited to the following:

(i) Respondent prescribed diazepam to Patient A on a long-term basis without a proper medical indication;

(ii) Respondent prescribed oxycodone and Oxycontin to Patient A on a long-term basis despite Patient A's active alcoholism;

(iii) Respondent prescribed diazepam, concurrently with oxycodone and Oxycontin, without proper tapering of these medications; and

(iv) Respondent improperly initiated, managed, and monitored Patient A's oxycodone and Oxycontin therapy by failing to timely refer Patient A for a pain management consultation; failing to refer Patient A for medication detoxification and substance addiction programs, including psychiatric and psychological evaluations relating thereto; escalating the dosage of oxycodone and Oxycontin, respectively, without properly addressing Patient A's development of pain

medication tolerance and addiction, as well as the possibility of opioid-induced hyperalgesia syndrome[5]; and failing to try different long-acting opiate therapy for Patient A; and

(v) Respondent failed to have a pain treatment contract with Patient A; he failed to obtain Patient A's informed written consent to prescribe pain medications to him; he failed to order routine urine toxicology testing to monitor potentially abusive and/or aberrant behaviors by Patient A; and he failed to document any discussions with Patient A regarding the analgesic effects, side effects, and functional goals of taking oxycodone and Oxycontin.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

39. Respondent has subjected his Physician's and Surgeon's Certificate No. G 58731 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 38, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 58731, issued to Respondent Martin C. Schulman, M.D.;

2. Revoking, suspending or denying approval of Respondent Martin C. Schulman, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Martin C. Schulman, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

[5] Opioid-induced hyperalgesia syndrome is a condition in which the long-term use of opiates induces a hypersensitivity to painful stimuli with more perceived pain.

4. Taking such other and further action as deemed necessary and proper.

DATED: September 13, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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